



## APPLICATION FOR APPROVAL OF THE QUALIFIED MEDICATION AIDE COURSE

State Form 47953 (R/4-03)

Indiana State Department of Health – Division of Long Term Care

**INSTRUCTIONS:** Please complete the appropriate sections on both sides of the application. **All applications must be completed in Sections A and D.**

### SECTION A: Training program information

**APPLICATION PURPOSE (check all that apply):**

- ☐ Initial approval; ☐ Renewal; ☐ Add Instructor (Section B); ☐ Add Clinical Site (Section C);  
☐ Remove Instructor: Name \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Street Address: \_\_\_\_\_

PO BOX #: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_

ZIP: \_\_\_\_\_ Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

**CLASSROOM SITE: (if different from above)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_

ZIP: \_\_\_\_\_ Phone number: \_\_\_\_\_

### SECTION B: Program Instructor information

Name: \_\_\_\_\_

Nursing License #: \_\_\_\_\_ Vocational License #: \_\_\_\_\_

**PLEASE PROVIDE SPECIFIC DATES & LOCATIONS FOR THE FOLLOWING:**

**QUALIFICATIONS:**

**COPIES OF THE Q.M.A. TRAIN-THE-TRAINER COURSE CERTIFICATE, R.N. LICENSE,  
OR VOCATIONAL LICENSE, MUST ACCOMPANY THIS APPLICATION**

## SECTION C:                      Practicum Sites

Name of Facility: _____
Address: _____ City _____
Name of Facility: _____
Address: _____ City _____
Name of Facility: _____
Address: _____ City _____

## SECTION D: Certification of QMA Program

I certify the above information is correct and the named facility/school in Section A will abide by the criteria set forth by 412 IAC 2.	
_____ Administrator of facility OR Director of non-facility based program	_____ Date

**Mail completed application, along with requested documentation to:**

INDIANA STATE DEPARTMENT OF HEALTH  
DIVISION OF LONG TERM CARE  
2 N. MERIDIAN ST., 4B  
INDIANAPOLIS, IN 46204

Please use additional applications for more than one instructor. Also, keep a copy of this application for your records.